

NOTICE
THIS APPLICATION WAS REVISED IN JUNE 2015
- PLEASE READ CAREFULLY -

Application For A Change In License

Complete the application and return it along with the appropriate application fee, and supporting documentation, if applicable, to the following address:

**STATE OF ALABAMA
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF PROVIDER SERVICES
P.O. BOX 303017 (MAILING ADDRESS)
MONTGOMERY, ALABAMA 36130-3017
THE RSA TOWER, SUITE 700, 201 MONROE STREET,
MONTGOMERY, AL 36104
(PHYSICAL LOCATION)**

Instructions for completing the application are shown below.

If you have any questions please call (334) 206-5175.

INSTRUCTIONS FOR COMPLETING A CHANGE IN LICENSE APPLICATION

SECTIONS I, II, III, AND IX MUST BE COMPLETED. Complete sections, IV, V, VI, VII, VIII only if the section is applicable to the requested action you have checked in item I.

Section I - Requested Action - Check each box that applies. Check the address change box if, for any reason, the street address has been changed by the post office. Check the box labeled relocation within the county where the facility is currently licensed if the actual facility is moving to a new location within the same county. Check the box labeled relocation to a different county, if the relocation will be to a different county than it is currently licensed. Please attach driving directions from Montgomery to the new location. **Check each box that applies.**

All facilities **except** abortion centers, regular assisted living facilities, independent clinical laboratories and independent physiological laboratories are required to obtain State Health Planning and Development Agency (SHPDA) approval for a bed increase, station increase or relocation. Any facility subject to the SHPDA regulations must provide a copy of SHPDA approval for all transactions requiring such approval or acknowledgement.

Applications for hospice relocations within the SHPDA approved service area must include a copy of the 35 day advance notice (showing the stamped date of receipt by SHPDA).

All facilities **except** independent clinical laboratories, independent physiological laboratories, in-home hospices, and sleep disorder centers are required to submit building plans to Technical Services for review and approval prior to a relocation, licensed bed increase or station increase. Please refer to Chapter 420-5-2, Payment of Plan Review Fees and Chapter 420-5-22, Submission of Plans and Specifications for Healthcare Facilities for additional information. You may call the Technical Services Unit at 334-206-5177.

Section II - Identifying Information - Name and address of facility - Indicate the official name and address of the facility. The name and address listed in this section will appear on the license certificate. If this application is for a name or address change, provide the new name or new address of the facility in the space provided on the left side of the application **and** provide the current name and current address of the facility as it is **currently** licensed with this agency in the space provided on the right side of section II. If there is **no change** in the facility name or address, only **complete the left side of section II.**

Administrator/Director - Give the name of the person officially designated by the governing authority as being in charge of the facility. Administrators for nursing homes, assisted living facilities and specialty care assisted living facility must provide their administrator's license number.

Section III - Current Facility Classification - Check the applicable classification type for which the facility is currently licensed.

Section IV - Bed Capacity Change - Complete this section if your facility has licensed beds and you are applying for a bed increase or decrease.

Current number of beds - the number of beds the facility is currently licensed to operate

Bed Increase - the number of beds you want to add.

Total number of licensed beds - the current number of beds plus the number of beds you want to add.

Section V - ESRD Station Change - Complete this section if you are licensed as an ESRD and are applying for an ESRD station increase or decrease.

Current ESRD stations - the number of stations the facility is currently licensed to operate

Station increase - the number of stations you want to add.

Total ESRD stations - the current number of stations plus the stations you want to add.

Specify the number and type of stations.

Section VI - Authorized Bed Capacity (for Hospitals Only) - Authorized bed capacity is the number of beds a hospital has available for inpatient care. The number of authorized beds is designated by the hospital (it may be less than, **but not more than** the licensed bed capacity.)

Section VII - Classification/Specialization Change - Provide the classification as the facility is currently licensed in the first blank. Provide the new classification/specialization in the second blank. If a Certificate of Need (CON) is applicable, the CON must accompany this application. **An ALF/SCALF conversion is not considered a classification/specialization change.** Therefore, do not use this section for ALF/SCALF conversions.

Section VIII - Legal Business Organization Name Change - Complete this section if the licensee has undergone a business organization name change. For example, if the facility is owned by a corporation and the corporation has a new corporate name, you must complete this section. The amended articles of incorporation, articles of organization, and limited partnership agreements which reflect the business organization name change should be submitted with this application along with the certificate of registration from the Secretary of State's Office. Please note, a general partnership is not required to obtain a certificate of registration from the Secretary of State's Office; however, you must attach a copy of the amended partnership agreement with this application.

Section IX - Authority - The Administrator, or other authorized official, must complete the certifying statement, attach a check or money order made payable to the Alabama Department of Public Health, if applicable, and return the application and supporting documentation, if applicable, to the address listed in the upper left hand corner of the application.

Additional Information:

Application Fees

- There is no fee for a name change, address change, relocation, or bed or station decrease.
- Bed Increase for Hospitals, Inpatient Hospices and Nursing Homes- \$200.00 plus \$5 for each **net gain bed**.
- Bed Increase for Assisted Living Facilities and Specialty Care Assisted Living Facilities – \$200 plus \$15 per each **net gain**.
- ESRD Stations - \$200 for an increase in ESRD stations. ESRD stations are not subject to the net gain fee.

Notice to All Certified Health Care Facilities and Those Seeking Certification

The Department of Public Health Licensure and Certification units must have a correct facility name and address that is consistent with the official name and address on record with the Center for Medicare and Medicaid Services (CMS) and their Medicare Administrative Contractor (MAC) - the Fiscal Intermediary.

To that end it is the policy of the Department to: (1) grant an initial license; (2) grant a new license reflecting a name change or address change or relocation of a licensed facility; and (3) approve certification of a licensed facility -- only when written confirmation has been received from the MAC that the facility has been approved. The name and address entered on the licensure application forms must be the exactly the same as that on the certification forms. An acceptable alternative is to submit in writing that the appropriate certification paperwork has been filed with the MAC.

Printing of License Certificates

License certificates are now available on-line. When a license is granted or renewed the license certificate can be printed on-line at <https://dph1.adph.state.al.us/FacilityCertificatePrint>. A facility ID and pin number will be provided and must be used to print license certificates.

<p style="text-align: center;">V ESRD STATION CHANGE</p>	<p>Current # of stations _____, plus / minus a(n) increase / decrease of _____ stations, for a total of _____ stations. <small>(circle one) (circle one)</small></p> <p>Breakdown of total stations:</p> <p>Hemo _____ Hemo Home Training _____ PD _____ PD Home Training _____ Isolation _____</p>
<p style="text-align: center;">VI AUTHORIZED BED CAPACITY (Hospitals Only)</p>	<p>Current authorized bed capacity is _____, plus / minus a(n) increase / decrease of _____ authorized beds for a <small>(circle one) (circle one)</small></p> <p>total authorized bed capacity of _____.</p>
<p style="text-align: center;">VII CLASSIFICATION/ SPECIALIZATION CHANGE (do not use this section for ALF/ SCALF conversions)</p>	<p>This facility is currently licensed as a(n) _____ and would like to change to a <small>(item checked in section III)</small></p> <p>_____. If this application is for a specialized critical access hospital, <small>(new classification/specialization)</small></p> <p>Supplement A, which is provided upon request, must be completed and submitted with this application.</p>
<p style="text-align: center;">VIII LEGAL BUSINESS ORGANIZATION NAME CHANGE</p>	<p>Current name of the business organization (corporation, partnership, etc also known as the licensee). _____</p> <p>_____.</p> <p>New name of the business organization (corporation, partnership, etc.) _____</p> <p>_____.</p> <p>Regardless of the type of business organization, amended articles of incorporation, articles of organization, or partnership agreement, whichever applies, must be submitted with this application. If the owner is a corporation, limited partnership or limited liability company, you must also submit documentation indicating this name change has been filed with the Secretary of State's Office.</p> <p>PLEASE NOTE: A change in corporate name, partnership name, etc. is not the same as a change of ownership. This form cannot be used to apply for a change of ownership.</p>
<p style="text-align: center;">IX FEE</p>	<p>Enclosed is a check or money order made payable to the Alabama Department of Public Health in the amount of</p> <p>\$ _____, as noted in the instructions of this application.</p>

Provide the name, phone number, and email address of a knowledgeable person who can supply details about this application. **PLEASE PRINT**

Name _____

Title _____

Address _____

City-State-Zip _____

Phone _____ Email _____

Administrator Attestation:

I declare, under penalty of perjury that I have not operated or allowed to be operated, this facility, or any other facility, without a license. I agree to operate this facility according to the Rules of the Alabama State Board of Health.

Printed Name

Signature

Date

NOTARIZED:

Sworn to and subscribed before me this _____

day of _____ 20_____.

(Notary Public)

20. Attestation of Responsible Person:

I declare, under penalty of perjury, that I have personal knowledge about the statements made in this application and certify that all statements are true and correct. To the best of my knowledge, neither the applicant; nor any of the principals, including myself, the owners, and the administrator have operated or allowed to be operated this facility, or any other facility, without a license. I certify that I am authorized to make this representation on behalf of the applicant.

Signature: _____ Printed Name: _____

Title/Position: _____ Date: _____

NOTARIZED:

Sworn to and subscribed before me this _____

day of _____ 20_____.

(Notary Public)